Wisconsin Health Insurance Risk Sharing Plan (HIRSP)

Suite 18, 6406 Bridge Road, Madison, Wisconsin 53784-0018 Telephone (608) 221-4551 (local), 1-800-828-4777 (toll free)

CHANGE NOTICE

☐ PLAN 1, Option A	(\$1,000 Deductible)				
PLAN 1, Option B	(\$2,500 Deductible)				
PLAN 2 (MEDICARE ONLY)	(\$500 Deductible)				

CHANGE IN		_			PLA	N Z (IVIEDICA	ARE UNL	(\$500	Deductible)
1. Last Name		First	Middle				1A. Telep	hone Numb	er
1B. Residence Address	Number	and Street	City	State	ZIP Code		1C. Date	of Birth (MN	M/DD/YYYY)
1D. Social Security Number	er	1E. Sex □ M □ F	1F. Marital Status		Married	Widov	wed	Divorced	Separated
2. Name Change	Previous L	evious Last Name Middle In						Middle Initial	
	Reason:	□ Marriage	☐ Divorce	□ Other			Effe	ctive Date _	
3. Address Change	New Addr	ess Street			C	city		State	ZIP Code
	Length of	residence at curre	ent address: From (N	/IM/DD/YYYY	<u></u>			to pre	sent date.
4. Employer Change	Your Emp	Your Employer (or parent's employer, if dependent child) Spouse's Employer							
Name									
Street Address									
City, State, ZIP									
Telephone									
A. Are you (or you	r parent, if a	dependent child)	currently:						
□ Employed fu	ıll time 🗆	Employed part	time Self-en	nployed		Unemploye	ed	□ Reti	red
B. Does your empl available for em		oouse's employer,	or in the case of a d	ependent chi	ld, your p	arent's empl	oyer have		urance plan
		above, are vou el	igible for any employ	er's health in	surance?		□ Ye		
,		•	e a brief explanation a						our spouse's or
parent's employe	er's health in	surance plan.							
5. Medicare Eligi	ibility	My Medicare He	ealth				Eff.	Date	/ /
Change		Insurance Num	ber is:				Ter	m. Date	/ /
6. Medicaid Stat Change	Are you currently covered by health insurance benefits under Medicaid (also referred to as Medical Assistance or T-19)? Yes No If "YES," please complete below.					al Assistance or			
	Elia	ible Effective			Eliai	bility Termina	ited		
		pplicable, comp			· ·	•			
		licaid 'ES." please provid	□ Yes □ de Medicaid number:	No		Wisconsin V			Yes □ No
						Supplementa	al Security		Yes □ No
7. Coordination of Benefits Change Is anyone named on this notice covered by any other medical plan?					□ No				
	Name under which policy is listed Type of Coverage			□ Drug	□ Vision				
		□ Single Plan Name of Other Insurance Company □ Family Plan							
	Effective Date (MM/DD/YYYY) Policy ID Number Group Number								
Signature	I	r Signature					Toda	y's Date	
Effective Date of Cha	-								
	X _								

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OHANGE IN	OHOL		I LANZ (MEDIC	(\$300 Deductible)		
1. Last Name	First	Middle		1A. Telephone Number		
1B. Residence Address	Number and Street	City State	ZIP Code	1C. Date of Birth (MM/DD/YYYY)		
1D. Social Security Number	er 1E. Sex □ M □ F	1F. Marital Status Sin		owed Divorced Separated		
2. Name Change	Previous Last Name	Previous Last Name First Name Midd				
_	Reason: Marriage	☐ Divorce ☐ Othe	r	Effective Date/		
3. Address Change	New Address Street		City	State ZIP Code		
	Length of residence at curre	ent address: From (MM/DD/)	YYY)	to present date.		
4. Employer Change Name	Your Employer (or parent's	employer, if dependent child	Spouse's Emp	loyer		
Street Address						
City, State, ZIP						
Telephone						
	r parent, if a dependent child)					
	Ill time	• •				
 B. Does your employer, your spouse's employer, or in the case of a dependent child, your parent's employer have a health insurance plan available for employees? ☐ Yes ☐ No 						
•	I "YES" to B above, are you el			□ Yes □ No		
D. If you answered "NO" to C above, please give a brief explanation as to why you are not eligible to be insured under your, your spouse's or parent's employer's health insurance plan.						
5. Medicare Eligi Change	My Medicare Ho Insurance Num			Eff. Date// Term. Date/ /		
6. Medicaid Stat	Are you currently cov T-19)?	•	efits under Medicaid (als "YES," please complete	so referred to as Medical Assistance or e below.		
	Eligible Effective	elete below.	Eligibility Termin	nated		
	Medicaid	□ Yes □ No	Wisconsin	Works □ Yes □ No		
	If "YES," please provid	de Medicald number:	Supplemen	ntal Security Income 🗆 Yes 🗆 No		
7. Coordination of Benefits Change Is anyone named on this notice covered by any other medical plan? Yes If "YES," please complete information below.						
— Benefits Char	Name under which po	•	Type of Cov □ Health	verage □ Dental □ Drug □ Vision		
	□ Single Plan □ Family Plan Name of Other Insurance Company					
	Effective Date (MM/DE	D/YYYY) Policy I	D Number	Group Number		
Signature	Your Signature	·		Today's Date		
Effective Date of Cha	ange					
	1					